

# STATE REGULATION OF THE NONPROFIT HEALTH INSURANCE INDUSTRY AT THE APPROACH OF NATIONAL HEALTH INSURANCE: GOALS, PROCEDURES AND RATIONALE

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## I. THE PROBLEM: THE NONPROFIT HEALTH INSURANCE INDUSTRY AS A FACTOR IN THE HEALTH CARE CRISIS

### A. *The Delivery of Health Care Service: Some Background*

To quote from the recently published book *Blue Cross: What Went Wrong?*, "The crisis in medical care has arrived as an American public issue,"<sup>1</sup> and current statistics reveal why this is so. Health care costs have been increasing much faster than the rate of inflation generally.<sup>2</sup> Public attention has been focused on this increase as more and more people begin to feel that the sharp rise in the price of health care has brought with it no commensurate rise in the quality of health care.<sup>3</sup> While Americans in fiscal 1973 spent \$94.1 billion (7.7 percent of the gross national product) on health and medical care,<sup>4</sup> Americans in low and lower-middle income brackets continue to receive thoroughly inadequate health care.<sup>5</sup>

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<sup>1</sup> S. LAW, *BLUE CROSS: WHAT WENT WRONG?* (1974); see generally E. KENNEDY, IN *CRITICAL CONDITION: THE CRISIS IN AMERICA'S HEALTH CARE* (1972); [OHIO] GOVERNOR'S TASK FORCE ON HEALTH CARE, FINAL REPORT (1973) [hereinafter cited as OHIO TASK FORCE].

<sup>2</sup> M. FELDSTEIN, *THE RISING COST OF HOSPITAL CARE* 10-13 (1971). In fiscal 1973, the average health bill for each person was \$441; in 1960, it was \$142; in 1950, it was less than \$80. This growth was two and one-half times as great as the increase in wage levels over the same period. HOUSE COMM. ON WAYS AND MEANS, 93d CONG., 2d SESS., NATIONAL HEALTH INSURANCE RESOURCE BOOK 8 (1974) [hereinafter cited as RESOURCE BOOK]. Indeed, projections are that spending on health care services will rise at an annual rate of 8.5 percent throughout the seventies, reaching more than \$113 billion by 1975 and almost \$165 billion by 1980. BUREAU OF DOMESTIC COMMERCE, U.S. DEPT. OF COMMERCE, UNITED STATES INDUSTRIAL OUTLOOK 1975 AT 399 (1972) [hereinafter INDUSTRIAL OUTLOOK].

<sup>3</sup> See M. MOOREHEAD, *A STUDY OF THE QUALITY OF HOSPITAL CARE SECURED BY A SAMPLE OF TEAMSTER FAMILY MEMBERS IN NEW YORK CITY* (1964); see E. Jancura, *The Economic Implications of the Use of Labor Resources by Hospitals*, 1972 (unpublished doctoral dissertation in Case Western Reserve University Library) at 68:

The concept of hospital quality is one filled with vague standards, unmeasurable values and just plain disagreement. . . . There is not even agreement whether quality of care has improved or deteriorated.

<sup>4</sup> *Id.* at 6.

<sup>5</sup> A. SOMERS, *HEALTH CARE IN TRANSITION: DIRECTIONS FOR THE FUTURE* ch. 4 (1971).

A country that can spend \$94.1 billion a year on health care<sup>6</sup> can hardly be said to be lacking in economic resources to solve the problem of providing health care to all its citizens. Commentators generally describe the problem as one not of lack of resources but of massive inefficiency, or of misallocation of existing resources.

Herbert Denenberg, a former Commissioner of the Pennsylvania Department of Insurance and a noted critic of the insurance industry, sums up these observations: "Almost all of the problems surrounding our present health delivery system rest on one point. That is the misallocation of our scarce resources in delivering health care."<sup>7</sup> Professor Sylvia Law of New York University Law School, author of *Blue Cross: What Went Wrong?*, states that "it is widely acknowledged that the American health care crisis is primarily one of organization, administration, and accountability."<sup>8</sup>

The recently released report of the Ohio Governor's Task Force on Health Care pointed to the reason underlying the misallocation problem:

The health care market is unique in that it is neither wholly a competitive market, nor is it a regulated market. As a result, responsibility for promoting cost containment in inducing efficiency is diffuse and fragmented. This has led to an upward bias on cost which, in turn, has promoted practices that feed inflation.<sup>9</sup>

The cost spiral in health care generally is particularly acute in the area of hospital costs. Hospital care absorbs a much higher percentage of the health care dollar than any other health service, significantly more than costs of physicians and dental services combined.<sup>10</sup> Moreover, while the costs of all phases of health care services have increased, it is the cost of hospital care that has risen the most rapidly.<sup>11</sup> Hospital insurance premiums are keeping pace; for example, the increases granted Blue Cross and Blue Shield of Greater New

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Particularly insightful is this comment by Ms. Somers: "[A]mong people age 25 to 64 who die, some 45 to 50 percent have neither hospital nor surgical coverage." *Id.* at 46. See E. KENNEDY, *supra* note 1.

<sup>6</sup> This was the figure for 1973. RESOURCE BOOK, *supra* note 2, at 6.

<sup>7</sup> PA. COMM'R OF INSURANCE, GUIDELINES FOR INCLUSION IN BLUE CROSS CONTRACT WITH DELAWARE VALLEY HOSPITAL ASSOCIATION AND RESPONSE OF BLUE CROSS (1973).

<sup>8</sup> S. LAW, *supra* note 1, at 2.

<sup>9</sup> OHIO TASK FORCE, *supra* note 1, at 104.

<sup>10</sup> In fiscal 1973, hospital care cost Americans \$36.2 billion—a 10.7 percent increase from 1972—while they paid a combined \$23.4 billion for the services of physicians and dentists, up 8.5 and 6.7 percent, respectively. RESOURCE BOOK, *supra* note 2, at 12.

<sup>11</sup> Between 1967 and 1972, the consumer price index for all items rose twenty-five percent, and costs of medical care rose thirty-three percent, while costs for hospital care rose seventy-four percent. OHIO TASK FORCE, *supra* note 1.

York for hospital insurance subscribers has been 16.8% in 1975, 7.4% in 1973, 14.8% in 1972, and 17.8% in 1971.<sup>11.1</sup> Nationwide, a single day spent in the hospital today costs almost five hundred percent as much as a single day ten years ago.<sup>12</sup> This price rise is not due primarily to higher wages paid to hospital employees, as some care providers have intimated; researchers have pointed out that the ratio of labor expenditures to total expenditures in a hospital may actually be declining.<sup>13</sup> Rather, the health insurance industry itself is a major cause of hospital cost increases.

The financing which the health insurance industry provides for health care is heavily concentrated in payments for hospital care.<sup>14</sup> Whereas the industry meets only about one fourth of all private health care costs, it provides over three fourths of the money consumers spend on hospital care. This statistic indicates the enormous impact which the health insurance industry can have on hospital costs.

There has also been a rapid growth in the number of health insurance plans.<sup>15</sup> By the end of 1972 about eighty percent of Americans under sixty-five years of age had some form of health insurance.<sup>16</sup> In this rapidly expanding industry, Blue Cross plays a vital role.

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<sup>11.1</sup> New York Times, Feb. 20, 1975 at 1.

<sup>12</sup> *Hearing Before Ohio Dep't of Insurance, In re Application for Rate Adjustment by Blue Cross of Lima, Ohio* 294, 312 (Dec. 19-20, 1973) (testimony of Sylvia A. Law, on file at Ohio Department of Insurance) [hereinafter cited as LIMA, OHIO HEARINGS]; see RESOURCE BOOK, *supra* note 2, at 22-23.

<sup>13</sup> See E. Jancura, *supra* note 3, at 77. Professor Jancura, citing H.G. Lewis's finding that "the majority of workers have been employed in industries whose average relative wages have been raised or lowered by unionism by no more than 4 per cent," seems to conclude in general that unionization of hospital workers is not an overriding factor in the huge increases in hospital costs. See RESOURCE BOOK, *supra* note 2, at 22-23.

In fact, wages for hospital employees have long lagged far behind that of wages for comparable work in industry. See, e.g., Kochery and Strauss, *The Nonprofit Hospital and the Union*, 9 BUFFALO L. REV. 255 (1960); Vladeck, *Collective Bargaining in Voluntary Hospitals and Other Nonprofit Operations*, 19TH ANNUAL N.Y.U. CONFERENCE ON LABOR, at 222 (Christensen, Ed. 1967). A few years ago it was revealed that 37 percent of hospital employees at a major Cleveland hospital were forced to apply to the county welfare department for financial aid for their families. Billington, *Hospitals, Unions and Strikes*, 18 CLEV. MAR. L. REV. 70, 73 (1969). Until recently hospital employees lacked the protection of national labor legislation. The Taft-Hartley Act, through the Tydings Amendment, exempted nonprofit hospitals from coverage. 29 U.S.C. § 152(2). Congress removed this exemption in 1974. P.L. 93-360.

<sup>14</sup> While health insurance benefits cover only twenty-six percent of total private consumer expenditures for health care, the benefits cover seventy-nine percent of all private consumer expenditures for health care. U.S. BUREAU OF CENSUS, 1973 STATISTICAL ABSTRACT 69 (1973).

<sup>15</sup> For a quick summary of the history of health insurance plans through the 1950's, see Simpson, *Nonprofit Hospital Plans*, 8 CLEV.-MAR.L.REV. 492 (1959). Simpson states that the modern concept of prepayment first became widespread in the 1930's. For a more extensive summary of the history up till the present, see S. LAW, *supra* note 1.

<sup>16</sup> RESOURCE BOOK, *supra* note 2, at 74-75. The scope and breadth of coverage varied.

Professor Law, in testimony at hearings on Blue Cross, stated that "Blue Cross stands in probably the most powerful position of the various institutions that make up the health care system in the country," and that "Blue Cross is perhaps the pivotal institution in the delivery of health care services in this country."<sup>17</sup>

The rationale of such strong statements can be explained as follows. As discussed above, hospital care accounts for the lion's share of the health care dollar. In Ohio and other states where Blue Cross has heavy market penetration, Blue Cross provides a typical hospital with approximately fifty percent of its revenues<sup>18</sup>—with about half of these revenues paid to the hospital by Blue Cross for provider services for subscribers and the remaining half paid by Blue Cross in its role as "intermediary" for government funds (mainly Medicare and Medicaid).<sup>19</sup> In some cases, Blue Cross has been known to administer up to seventy percent of the income of hospitals of an area.<sup>20</sup> The role of Blue Cross is so crucial that Professor Law has stated that "it has the power, if [it] had the will, to turn around the health care crisis."<sup>21</sup>

This article suggests that the rapid rise in hospital costs is owing primarily to the largely unregulated contractual and economic relationship between Blue Cross<sup>22</sup> organizations and their member hospi-

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As those sixty-five years of age and older have protection through medicare, the statistics for this age bracket are less relevant.

<sup>17</sup> LIMA, OHIO, HEARINGS, *supra* note 12, at 291.

<sup>18</sup> Although Blue Cross now trails the sum total of all commercial insurers combined (it has about thirty-five percent of the under sixty-five private consumer market and all commercial about fifty-seven percent), Blue Cross has recently regained its position of market dominance as intermediary for medicare and medicaid. S. LAW, *supra* note 1, at 2.

<sup>19</sup> *Id.* at ch. 2. The term "intermediary" is explained in the RESOURCE BOOK, *supra* note 2, at 429, as describing the function of Blue Cross under medicare:

The Medicare program is under the overall direction of the Secretary of Health, Education and Welfare. Within the department, the Bureau of Health Insurance of the Social Security Administration is responsible for policy and administrative control the program, with much of the day-to-day operational work of the program performed under contract by 132 commercial insurance companies and Blue Cross/Blue Shield plans. These organizations have the responsibility as intermediaries between the government and the provider for reviewing claims for benefits and making payments. . . . Under the hospital insurance part of the program, groups or associations of providers, on behalf of their members, nominate a public or private agency or organization to serve as intermediary in the claims process.

*Id.* at 432. Oftentimes Blue Cross is the nominee.

<sup>20</sup> This is true, for example, of Blue Cross of Lima, Ohio. See LIMA, OHIO, HEARINGS, *supra* note 12, at 106.

<sup>21</sup> *Id.* at 291.

<sup>22</sup> The origin and development of the term "Blue Cross" is documented in S. LAW, *supra* note 1, at 11:

The name "Blue Cross" and the Blue Cross insignia were owned by the American Hospital Association [AHA] until 1972. . . . In 1936, as part of the AHA effort

tals. This relationship, in fact, goes to the heart of the cost crisis in the delivery of health care services, and, as shown above, Blue Cross is the primary purchaser of hospital services.

The major national health insurance bills presently in Congress do nothing to deprive Blue Cross of its critical position in health care services. Thus some authorities suggest that, unless the relationship between Blue Cross and member hospitals is made the object of effective regulation by the states, most proposed national health insurance plans will simply fuel the sources of the present inflation in hospital costs. As a consequence, national health insurance premiums may rise so sharply that in the near future health care insurance may be as unaffordable as health care itself is today.<sup>23</sup> It is the object of this article to discuss the inflationary effect of the relationship between Blue Cross and the hospitals, to examine the procedures available to the states to regulate the relationship and the goals states might pursue when using these procedures, and to explore the rationale underlying the use of each of these procedures.

### B. *Inflationary Practices of Blue Cross*

Blue Cross and Blue Shield<sup>24</sup> are provider-sponsored plans which offer free choice of hospital and doctor and furnish mainly "service benefits."<sup>25</sup> Two other major types of health insurance plans exist.<sup>26</sup>

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to promote the establishment of prepaid hospitalization plans, it created a Committee on Hospital Services, which, in 1946, became the Blue Cross Commission of the AHA. Until 1960 the Commission performed the national coordinating function among Blue Cross plans. In 1960 most of the functions of the Blue Cross Commission were transferred to the Blue Cross Association [BCA], a non-profit Illinois corporation. The BCA and AHA maintained close coordination through interlocking directorates, with the AHA designating three members of the Blue Cross board and BCA designating two members to the board of the Hospital Association. Other functions, including the administration of the approval program for the use of the Blue Cross insignia, were retained by the AHA. In 1971 the AHA and Blue Cross agreed in principle that the ownership of the Blue Cross name and insignia should be transferred from the AHA to the BCA. . . . The organizations also agreed to eliminate the interlocking directorate and substitute a joint committee to facilitate communication between the two groups.

<sup>23</sup> See generally, *Hearing Before Ohio Dep't of Insurance, In re Adoption of Rule IN-1739.01* (June 26, 1974) (testimony of Sylvia A. Law on file at Ohio Department of Insurance) [hereinafter cited as *Ohio Rule Hearings*].

<sup>24</sup> Of the two major provider plans, Blue Cross is by far the larger; its annual income is about 2.5 times that of Blue Shield. A. SOMERS, *supra* note 5, at 49.

<sup>25</sup> The term "service benefits" describes a system whereby, in return for advance premium payments to the provider-sponsored plan, a hospital or doctor participating in the plan will provide specified medical or hospital services to the subscriber on a fee-for-service basis and will be paid directly by the plan.

<sup>26</sup> ROEMER, *HEALTH INSURANCE EFFECTS: SERVICES, EXPENDITURES, AND ATTITUDES UNDER THREE TYPES OF PLANS* 1 (1972).

Commercial insurance companies offer health care insurance policies featuring free choice of provider, under which the company directly indemnifies the subscriber for all or part of the fees paid by him to obtain specified medical services (though some companies have recently begun to provide service benefits). In addition, there are pre-paid plans offering services to subscribers directly through a group medical practice organization in return for fixed monthly payments to the organization, with no fee-for-service charges to either the subscriber or the plan.<sup>27</sup> This last plan is commonly referred to as HMO, for Health Maintenance Organization, and it in effect "means near-total medical care for a fixed monthly fee."<sup>28</sup>

A thorough study comparing the three types of health insurance plans was recently released.<sup>29</sup> The study, which sent questionnaires to subscribers to each type of plan in Los Angeles County, California, brought out the following facts: (a) The average stay for a patient in a hospital was 4.9 days per year for HMO subscribers, while it was 7.4 and 8.5 days per year for subscribers of provider-sponsored and commercial plans, respectively; (b) hospital admissions were almost fifty percent higher in the provider-sponsored plans than in the commercial or HMO plans; (c) the percent of families with no visits to a doctor over a three-month period was lowest for HMO subscribers; (d) consumer dissatisfaction was lowest among HMO subscribers and highest among the subscribers of the provider-sponsored plans; and (e) total expenditures per family per year, including both premiums and out-of-pocket expenses, was \$323 for HMO, \$364 for commercial, and \$447 for provider-sponsored plans.<sup>30</sup>

It thus seems reasonable to conclude that HMO's make a better use of resources than the other two plans. Other reports indicate a similar conclusion.<sup>31</sup> The apparent reason for this greater efficiency is that because the HMO's base "provider reimbursement on a capitation<sup>32</sup> instead of a fee-for-service basis, a greater incentive exists to control cost."<sup>33</sup> People spend less time in the hospital, and there is a heavier emphasis on ambulatory services.<sup>34</sup> Nor do the studies

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<sup>27</sup> Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887 (1971) [hereinafter cited as *Role of Prepaid*] gives a complete explanation of prepaid health insurance.

<sup>28</sup> BUSINESS WEEK, January 12, 1974, at 58.

<sup>29</sup> ROEMER, *supra* note 26.

<sup>30</sup> *Id.*

<sup>31</sup> *Role of Prepaid*, *supra* note 27, at 933; OHIO TASK FORCE, *supra* note 1, at 111.

<sup>32</sup> "Under this compensation scheme, the medical group partnership is provided an amount of money equal to a fixed per capita sum for each subscriber multiplied by the number of subscribers enrolled." *Role of Prepaid*, *supra* note 27, at 907.

<sup>33</sup> OHIO TASK FORCE, *supra* note 1, at 111.

<sup>34</sup> ROEMER, *supra* note 26, at 34.

indicate that HMO's provide a lower standard of care,<sup>35</sup> although they may cause weakening of the traditional doctor-patient relationship.<sup>36</sup>

In contrast to the apparent efficiency of the HMO's, Blue Cross has been criticized as having an insurance system in which old inefficiencies are preserved and new ones created. Several characteristics of the contractual relationship between Blue Cross and member hospitals have freed hospitals from the necessity of controlling costs and thus are among the prime causes of the steep rise in hospital costs.<sup>37</sup>

The first of these inflationary practices is that traditionally Blue Cross has reimbursed member hospitals at one hundred percent or more of the hospitals' "reasonable costs" incurred in treating Blue Cross subscribers.<sup>38</sup> One type of reimbursement contract used by Blue Cross calls for a flat one hundred percent cost reimbursement, the inflationary tendencies of which are obvious.<sup>39</sup>

Another typical contract calls for reimbursement by Blue Cross to a hospital of ninety-seven percent of what it charges a subscriber for the care he receives or 108 percent of what it costs the hospital to treat the subscriber, whichever is less.<sup>40</sup> At first glance it might seem that the ability of Blue Cross to purchase care at three percent

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<sup>35</sup> *Role of Prepaid*, *supra* note 27, at 933; ROEMER, *supra* note 26. HMO's have not yet experienced the rapid growth predicted for them, allegedly due in part to "consumer ignorance," in part to bureaucratic slowdowns in Washington, and in part to "nonaggressive salesmanship" by HMO advocates. Wall St. Journal, Feb. 11, 1975, at 1.

<sup>36</sup> *Role of Prepaid*, *supra* note 27, at 939-41. The HMO plans, however efficient they may appear from a statistical viewpoint, occupy only a very small part of the health insurance market (about five percent, according to SOMERS, *supra* note 5, at 53). But this may change rapidly in the near future. Congress recently passed P.L. 93-222, which provides \$365 million over the next two to five years for grants and loans to HMO's and for research and education programs about HMO's. Congress in effect endorsed the HMO concept and is taking action to encourage more participation in the plans. See generally, RESOURCE BOOK, *supra* note 2, at 80-81.

<sup>37</sup> E.g., LIMA, OHIO, HEARINGS, *supra* note 12, at 306 (statement of Sylvia Law).

<sup>38</sup> E. Jancura, *supra* note 3, states at 15-16:

The policy of reimbursing hospitals for their costs produces little or no pressure on individual hospitals to attempt to hold their costs down. Installation of sophisticated equipment and provision of specialized services, for example, are frequently motivated by their prestige value without regard to the increase in costs which they occasion.

Except for the rather intangible influence of unfavorable comparison to industry-wide average costs, there is no pressure to force hospitals to control their costs. The desire for prestige when unchecked by the need to control costs can often lead to the expensive expansion of facilities when there is insufficient demand to use them at their lowest cost.

<sup>39</sup> See, e.g., Stark County Inter-Hospital Agency Agreement (effective January 1, 1959) (on file at Ohio Department of Insurance).

<sup>40</sup> See, e.g., Inter-Hospital Agency Contract (Lima, Ohio) (as amended Dec. 17, 1969) (on file at Ohio Department of Insurance).

less than the cost to a patient not insured by Blue Cross is an economic advantage to Blue Cross subscribers. Also at first glance, the ninety-seven percent-of-charges/108 percent-of-cost formula seems like a cost-control device since it keeps hospitals from charging more for care of a patient than what it costs.

However, an analysis of the curious way in which Blue Cross and the hospitals define the term "reasonable cost" shows that the formula does nothing to control hospital costs and in fact may act as a spur to them. Professor Law points out that the "reasonable cost" of treating a patient may include that patient's pro rata share of numerous items only remotely related to patient care, such as a hospital's lobbying and public relations expenses, depreciation on new facilities donated to the hospital by local philanthropy, and a two percent surcharge (meaning that a hospital can charge Blue Cross two percent more for the care of a patient than the one hundred percent-of-cost reimbursement formula would otherwise call for).<sup>41</sup> The inclusion of these items results from allowing Blue Cross and the American Hospital Association to define for themselves the term "reasonable cost." These organizations made "no effort . . . to determine whether total hospital costs, or any component thereof, were reasonable in amount according to some market standard."<sup>42</sup> No matter how cost is defined, the fact that hospitals can customarily "charge" patients less for care than it "costs" shows that the term "cost" is used by Blue Cross and hospitals in a way that has little in common with normal business usage.

Contracts between Blue Cross and member hospitals may further undermine the cost-consciousness of the latter by making Blue Cross subservient to the hospitals. Language from the reimbursement contract between Canton (Ohio) Blue Cross and its member hospitals is typical:

The Participating Hospitals and each of them appoint Blue Cross to be their exclusive agent to carry out and administer the program for furnishing hospital services contemplated by this agreement; to procure subscribers; to collect fees to be paid for Service Contracts; to distribute among hospitals the funds so collected in the manner and at the times herein provided and to do any and all acts and things necessary in connection with or incidental to the

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<sup>41</sup> See S. LAW, *supra* note 1, at 110-15; see also LIMA, OHIO, HEARINGS, *supra* note 12, at 288-91.

<sup>42</sup> *Id.* at 91.



carrying out of this agreement, which appointment shall be irrevocable during the participation of such hospital in this agreement.<sup>43</sup>

At best, such contract provisions tend to divide Blue Cross' loyalties, which accounts for the traditional unwillingness of Blue Cross to examine critically hospital construction,<sup>44</sup> hospital admissions,<sup>45</sup> length of hospital stay,<sup>46</sup> and other crucial aspects of hospital operations that determine the level of health care efficiency.

A brief comparison of the approaches of HMO's and Blue Cross to the problem of the construction of excessive hospital bed capacity will demonstrate the costliness of the unwillingness of Blue Cross to control "overbedding." Those HMO's like the Kaiser Foundation Plan which maintain their own hospitals keep their number of hospital beds relatively low and their bed occupancy rates relatively high.<sup>47</sup>

Since it costs a hospital two thirds as much to operate an empty bed as a full bed,<sup>48</sup> it is apparent that the lower the occupancy rate of a hospital's beds, the more inefficient is that hospital's operation.<sup>49</sup> In mid-1971 hospitals in the United States were operating at 73.5 percent of capacity, down almost two percent from a year earlier.<sup>50</sup> Since there is reason to believe that Blue Cross encourages hospital admissions and thus the need for hospital beds in the first place<sup>51</sup> and since experts suggest that Blue Cross, unlike HMO's, does nothing

<sup>43</sup> Stark County Inter-Hospital Agency Agreement, *supra* note 39; Inter-Hospital Agency Contract (Lima, Ohio), *supra* note 40.

<sup>44</sup> Until recently, of the seven Blue Cross plans operating in Ohio only one had an agreement with its local regional health planning agency not to reimburse hospitals for construction costs spent on facilities not approved by the planning agency.

<sup>45</sup> It is estimated by the Ohio Governor's Task Force on Health Care that fifteen to thirty percent of hospital admissions are unnecessary or inappropriate. OHIO TASK FORCE, *supra* note 1, at 105.

<sup>46</sup> A 1967 study of northeast Ohio hospitals found that those patients covered by third parties remained in the hospital nine to forty percent longer than self-pay patients with the same diagnosis. *Id.*

<sup>47</sup> One such HMO keeps its ratio at about 2.0 beds per 1,000 subscribers, a ratio much below that prevailing generally in the United States. *Role of Prepaid*, *supra* note 27, at 939-41. In Ohio, for example, the Cleveland and Columbus metropolitan statistical areas each have 4.4 beds per 1,000 persons. U. S. BUREAU OF CENSUS, 1973 STATISTICAL ABSTRACT 854 (1973).

<sup>48</sup> INDUSTRIAL OUTLOOK, *supra* note 2, at 396.

<sup>49</sup> By 1971 the average daily hospital rate, not including physicians' fees, reached \$90. *Id.*

Recognizing the importance of hospital occupancy rates in the current crisis of rising health care costs, the Department of Health, Education, and Welfare has recommended to the state agencies which administer the Hill-Burton program that if a state plans its hospital bed needs on the basis of separate services, bed occupancy rates should be ninety percent for medical-surgical, seventy-five percent for obstetrics, and seventy-five percent for pediatrics. If planning is not separate, the overall bed occupancy rate of a hospital should be eighty-five percent. HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION, DEP'T OF HEALTH, EDUCATION AND WELFARE, POLICY MEMORANDUM, HEALTH CARE FACILITIES SERVICE (1973).

<sup>50</sup> INDUSTRIAL OUTLOOK, *supra* note 2, at 396.

<sup>51</sup> See note 30 *supra*; see note 45 *supra*.

to control the number of hospital beds,<sup>52</sup> it is clear that at least some of the blame for the high rate of unoccupied beds is attributable to Blue Cross.

A third reason Blue Cross practices promote inefficiencies in hospital operation is that Blue Cross plays a "safety valve" role as guarantor of hospital solvency.<sup>53</sup> So marked is the last tradition that Blue Cross contracts commonly provide that in the event the Blue Cross plan is dissolved its contingency reserves (built up from subscriber premium payments) will be distributed to Blue Cross member hospitals.<sup>54</sup>

Still another inflationary practice followed by some Blue Cross plans is that of allowing a Blue Cross "Hospital Advisory Council" (made up entirely of hospital administrators from Blue Cross member-hospitals) to review applications by individual member-hospitals for increases in their charges.<sup>55</sup> At one Midwestern plan, the procedure is for a hospital administrator to submit his application for an increase first to the hospital's board of trustees, then to Blue Cross, and finally to the Hospital Advisory Council, which has the power to accept, modify, or reject the application.<sup>56</sup> Because all hospital administrators in this particular plan are operating under a reimbursement formula of ninety-seven percent-of-charges/105 percent-of-costs and each administrator will periodically be put in the role of applicant before the council, it is not difficult to see that this practice does little to control costs. Recent statistics confirm that the procedure has little cost-control effect: of the twenty-nine charge increase applications made to the Hospital Advisory Council of this Midwestern plan in 1971, twenty-four were accepted, four were modified, and only one was rejected.<sup>57</sup>

The economic effect of all of these practices by Blue Cross is set forth in the following exchange, which took place at the Lima, Ohio, rate hearing held by the Ohio Department of Insurance:

Q.: [by Mr. D. Brown (one of the authors of this article) for the Ohio Department of Insurance] Does that agreement [of the Blue Cross Association with its member hospitals] contain any language about comprehensive health planning?

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<sup>52</sup> ROEMER, *supra* note 26, at 24.

<sup>53</sup> See note 15 *supra*. For a discussion by a court of this traditional view of Blue Cross, see *Borland v. Bayonne Hospital*, 122 N.J. Super. 387, 300 A.2d 584 (1973).

<sup>54</sup> See e.g., *Stark County Inter-Hospital Agency Agreement*, *supra* note 39.

<sup>55</sup> See *Hearings Before Ohio Dep't of Insurance, In re Application of Blue Cross of Central Ohio for Change of Rates for Direct Pay Subscribers* (August 9-10, 1972) (on file at Ohio Department of Insurance) [hereinafter cited as *Columbus, Ohio, Hearings*].

<sup>56</sup> *Id.* at 55.

<sup>57</sup> *Id.* at 55-56.

A.: [by Mr. Temmer, Executive Director of Lima, Ohio, Blue Cross] No.

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Q.: Have you ever, as a matter of policy, refused to provide services to your subscribers at a hospital which had been constructed or expanded without approval of the local health planning agency?

A.: No, because the occasion has never arisen. It has never been a question.

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Q.: If you were a hospital administrator at one of the hospitals with which you have become familiar and were faced with a choice of purchasing one operating table from one seller or another substantially more expensive one from another seller and they had substantially the same characteristics, would the Inter-Hospital Agency Agreement reimbursement formula which reimburses at 108 percent of cost offer you any motivation to choose the cheaper of the two?

A.: No.<sup>58</sup>

The hospitals need not gear their operations toward efficiency when they know Blue Cross will always reimburse them in full for whatever costs they incur.

These Blue Cross practices indicate an allegiance by Blue Cross to the providers rather than to the consumers of health care, a point that has been commented on frequently in recent years. Professor Law states that the providers of health care, and in particular the hospitals, control Blue Cross.<sup>59</sup> Dr. Starkweather comments: "Most Blue Cross plans were sponsored by hospitals, and hospitals continue to heavily influence their affairs."<sup>60</sup> Senator Kennedy and others point out that in the past the boards of Blue Cross have been dominated by provider interests, mainly hospital interests.<sup>61</sup> The composition of the board is slowly changing,<sup>62</sup> but heavy influence by providers continues nonetheless.<sup>63</sup>

Symptomatic of the lack of representation of subscriber interests by Blue Cross is an increasing trend over the years by provider plans

<sup>58</sup> *Lima, Ohio, Hearings, supra* note 12, at 231, 266.

<sup>59</sup> *Id.*; S. LAW, *supra* note 1, at ch. II.

<sup>60</sup> Starkweather, *Regulation of Health Insurance: A Review; Part I*, 1970 MEDICAL CARE REV. 335, 338.

<sup>61</sup> E. KENNEDY, *supra* note 1, at 209. See also Starkweather, *supra* note 60, at 339.

<sup>62</sup> E. KENNEDY, *supra* note 1, at 209; see note 92 *infra*.

<sup>63</sup> OHIO TASK FORCE, *supra* note 1, at 107. Significantly, Congress has sought to avoid this pitfall of conflicts of interest in the HMO's. P.L. 93-222 requires a board one-third comprised of subscribers and, further, equitable representation of the poor. See H.R. CONF. REP. NO. 93-714 at 35.

to become more like the commercial plans.<sup>64</sup> Those organizational characteristics that used to separate the Blue Cross plans from commercial plans have either remained in form only or ceased to exist entirely.<sup>65</sup> Community sponsorship of Blue Cross which allows it special tax advantages, is being attacked on the ground that Blue Cross corporations are no more nonprofit than mutual insurance companies.<sup>66</sup> The practice of establishing the same premium rate levels for all subscribers in the same community ("community rating") is now being abandoned by Blue Cross in favor of a "merit rating" (sometimes called "experience rating") system, by virtue of which the rates of group subscribers are based on the loss experience of their group alone.<sup>67</sup>

Congress has firmly committed insurance regulation to the states through the McCarran Act.<sup>68</sup> Therefore, any impetus to change the relationship between Blue Cross and hospitals must come from the states. The problem becomes more urgent as national health insurance proposals come closer to adoption. All of the proposals call for putting billions more dollars into the hands of health insurance subscribers, and some of them also call for use of Blue Cross as an insurance carrier and/or an intermediary.<sup>69</sup> An excerpt from a state insurance department order denying a rate increase to one Midwest-

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<sup>64</sup> Starkweather, *supra* note 60, at 345-46; O. DICKERSON, *HEALTH INSURANCE*, Ch. 10, *Medical Expense: Problems and Issues* (3d ed. 1968).

<sup>65</sup> O. DICKERSON, *supra* note 64, at 323.

<sup>66</sup> *Id.* at 324; see *Hospital Service Association of Toledo v. Evatt*, 144 Ohio St. 179, 57 N.E.2d 928 (1944).

<sup>67</sup> Starkweather, *supra* note 60, at 350. An interesting example of a switch to merit rating occurred in Canton, Ohio. At a hearing held by the Ohio Department of Insurance on a rate increase request by Canton Blue Cross (Blue Cross Hospital Plan, Inc.), Blue Cross President Parker attributed the decision to abandon community rating to "pressures from our big groups and from our competitors." Under merit rating, nongroup (or "direct pay") subscribers paid premium rates based only on the loss experience of all other nongroup subscribers. Shortly thereafter, Blue Cross began to show losses on its direct pay business, even though overall the financial position of the plan grew stronger. At a subsequent rate hearing held July 5-6, 1972, Blue Cross argued that considerations of fairness dictated that each category of business "pay its own way." *Hearing Before Ohio Dep't of Insurance, In re Application for Rate Increase by Blue Cross Hospital Plan, Inc.* (July 5-6, 1972). Seemingly, then, large groups of subscribers managed to capture for themselves the advantage of being insured by a tax-exempt, non-profit insurer, while eliminating from their rating structure the higher risk subscribers (of those who leave employment, the unhealthiest have the highest incentive to retain insurance coverage and thus to enter the nongroup category) in their communities. A good subject for research might be whether the incentive to move to merit rating resulted from labor contracts requiring employees at large plants to pay the entire cost of their employees' health insurance and thus involving, for the first time, a direct sale of large amounts of insurance from Blue Cross to big employers. Employees could be expected to press for merit rating if that would decrease insurance costs.

<sup>68</sup> 15 U.S.C. §§ 1011-1012 (1971).

<sup>69</sup> See notes 92-94 *infra*.

ern Blue Cross plan summarizes the new identity which Blue Cross must be made to assume if change is to come:

Blue Cross has failed to exert any effective influence over its member hospitals to operate more efficiently and has thereby failed to control spiraling hospital costs in the Northwest Ohio area. Blue Cross must shed its traditionally paternalistic attitude toward the hospitals and assume the position of vigorously representing the interests of its subscribers. Blue Cross has the duty of seeing that its subscribers obtain the best health care possible for their dollar by making every effort to compel member hospitals to effect economies and to monitor utilization.<sup>70</sup>

### C. *The Role of Blue Cross under the National Health Insurance Proposals*

The Ninety-third Congress, second session, considered ten proposals for a national health insurance (NHI) plan.<sup>71</sup> Of the ten, three—the Nixon (Ford) Administration plan, the Kennedy-Mills plan, and the Long-Ribicoff bill—are likely to be reintroduced in substantially the same form in the Ninety-fourth Congress and are given a significant chance of passage in 1975.<sup>72</sup> If an NHI bill passes in the near future, it will probably combine some of the features of all three plans. Importantly, each of the three plans contemplates a large role for Blue Cross.<sup>73</sup>

The Comprehensive Health Insurance Act of 1974 (the Nixon bill) would make health insurance available to all Americans through three separate programs: (a) an employee health insurance plan (EHIP), offered at a person's place of employment and underwritten by an existing private insurance carrier, with the cost of the insurance to be shared by employer and employee (first on a 65/35 percent basis; after three years, on a 75/25 percent basis—in each case with the employer paying the larger share); (b) an assisted health insurance plan (AHIP), covering people with low income and others not eligible for EHIP or medicare, with federal and state governments paying

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<sup>70</sup> Superintendent De Shetler, Ohio Dep't of Insurance, Denial of Blue Cross of Northwest Ohio Rate Increase, Nov. 24, 1972 (unreported). Cited in *In re Blue Cross of Northwest Ohio*, Case No. 73AP-158 at 4 (Ct.App. Franklin Co. 1973).

<sup>71</sup> The National Health Care Services Reorganization and Financing Act of 1973 (H.R. 1); The Health Security Act of 1973 (H.R. 22, S. 3); The National Catastrophic Illness Protection Act of 1973 ("Medicredit") (H.R. 2222, S. 444); National Health Care Act of 1973 (H.R. 5200, S. 1100); The National Comprehensive Health Insurance Act of 1974 (administration bill) (H.R. 12684, S. 2970); The National Health Insurance and Health Services Improvement Act of 1973 (S. 915); The Catastrophic Health Insurance and Medical Assistance Reform Act (S. 2513); The Comprehensive National Health Insurance Act of 1973 (H.R. 13870, S. 3286).

<sup>72</sup> See Rivlin, *Agreed: Here Comes National Health Insurance*, N.Y. Times, July 21, 1974 (Magazine) at 8 *et seq.*; see generally, 4 NATIONAL HEALTH INSURANCE REPORTS 1-2 (1974).

costs beyond the means of the person insured; and (c) an expanded medicare program, with much the same financing mechanism that is used today.<sup>74</sup>

The Nixon bill would have the federal government establish standards for eligibility under the three plans, define the services to be reimbursed, and then assign many of the administrative duties of the program to the states. Significantly, states would contract with intermediaries to offer the basic plan to all residents enrolling in AHIP and would review for reasonableness premium rates filed by private insurance carriers offering coverage under EHIP. Private insurance carriers would be required to disclose information with regard to services covered, rates, and the relation between premiums and benefits paid.<sup>75</sup>

The Catastrophic Health Insurance and Medical Assistance Reform Act (the Long-Ribicoff bill) would apply mainly to persons now eligible for medicare or medicaid.

It would establish a catastrophic illness health insurance plan, federally administered and federally financed by a .3 percent increase in social security taxes. The bill also proposes the replacement of medicaid with a uniform national program of medical benefits for low-income persons, administered by the Social Security Administration. Both programs would use the same administrative mechanisms used for the administration of medicare, including medicare's carriers and intermediaries.<sup>76</sup>

The Comprehensive National Health Insurance Act of 1974 (the Kennedy-Mills bill) would establish a contributory program of national health insurance under the Social Security Act offering comprehensive health care benefits to all Americans not covered by medicare.

The bill would repeal the present medicaid program. The national health program would be financed by contributions from employers, employees, the self-employed, those with unearned incomes, and, for certain additional benefits for low-income persons, by general revenues. A national health insurance trust fund would be established to receive and hold separate from the federal budget contributions to the program, which would be administered by a reconstituted Social Security Administration. For institutional (*e.g.*, hospital) services, the Social Security Administration would use intermediaries

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<sup>73</sup> The following summaries of these three plans are, with minor modifications, taken from the NATIONAL HEALTH INSURANCE RESOURCE BOOK, *supra* note 2.

<sup>74</sup> RESOURCE BOOK, *supra* note 2, at 558-61.

<sup>75</sup> *Id.*

<sup>76</sup> *Id.* at 563-65.

much as it now does under medicare. For physicians' and other non-institutional services, private insurance carriers selected by employers with 1,000 or more employees would administer the program for that employer's employees and dependents, and these employers would have the option of dealing directly with the Social Security Administration. For people not covered by large employers, contracts would be awarded on a competitive basis by the Social Security Administration to private insurance carriers for given geographical areas of the country.<sup>77</sup>

Of these three major NHI proposals, the Kennedy-Mills plan seems to contemplate the smallest role for Blue Cross.<sup>78</sup> Nevertheless under all these national health insurance proposals Blue Cross will continue to operate in its traditional role as a private insurance carrier and/or in its more recently assumed role as an intermediary for federal funds. Similarly, state regulatory agencies will continue to be called upon to regulate Blue Cross rates, rating structures, and internal policies, though none of the bills prescribes the standards the state will have to apply.<sup>79</sup>

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<sup>77</sup> *Id.* at 556-68.

<sup>78</sup> See generally Rivlin, *supra* note 72.

<sup>79</sup> One method currently proposed for controlling hospital costs is the establishment of state rate-setting commissions empowered to set for each hospital the rate at which it would be reimbursed by all insurers and, in some states, authorized to determine whether or not new facilities should be built. Some form of rate-setting commission is already in operation in a small number of states, including New York and Massachusetts. For a discussion of the new Maryland and Connecticut commissions, see *Some States Try Surgery on Hospital Costs, With Maryland and Connecticut Leading The Way*, Wall Street Journal, Dec. 10, 1974, at 4, cols. 1-3. With the strong approval of the American Hospital Association and the Blue Cross Association, attempts are being made to establish commissions in more states.

Increasingly, however, questions are being asked about the ability of these commissions to control hospital costs. In his article entitled *Regulation of Health Facilities and Services by "Certificate of Need,"* 50 VA. L. REV. 1143 (1973), Clark Havighurst criticizes in general the public utility model as inappropriate for regulating the hospital care establishment.

Others base their criticism of rate-setting commissions on these grounds: (1) commissions often fail to subject the hospital-Blue Cross reimbursement contract to regulatory scrutiny, so that hospitals continue to be insulated from normal market forces by provisions for reimbursement at one hundred percent or more of cost; (2) they establish a unitary state-wide approach to the problem of controlling hospital costs in local communities, thus sacrificing the creativity and innovation that can come from local control; (3) they fail to take advantage of the expertise in the financing and delivery of hospital care already possessed by those presently in the health insurance industry; (4) they entail very high compliance costs (e.g., Massachusetts require 150 employees and an annual budget of \$1.5 million for its rate-setting commission); and (5) they are not highly visible and thus are easily susceptible to domination by the regulatees. Interview with William Shkurti, Health Economist, Ohio Department of Insurance, Oct. 28, 1974.

Many of these problems can be avoided if Blue Cross and others presently financing hospital care are forced to exercise cost control responsibility through the reimbursement contract and other means. Effective regulation of these insurers by presently established state insurance departments is essential to that end.

Since at present about twenty percent of the civilian population under sixty-five years of age is wholly uninsured<sup>80</sup> and since many of those eighty percent insured have less than comprehensive coverage,<sup>81</sup> NHI proposals like the Kennedy-Mills and Nixon bills which make broad coverage available to all persons can be expected to increase health expenditures significantly. Blue Cross is urging strongly that it be permitted to occupy a central role under NHI,<sup>82</sup> and it appears that Blue Cross will prevail. At the minimum, under most NHI proposals Blue Cross should continue as insurance carrier for the seventy-six million persons it now insures<sup>83</sup> and should retain its additional role as intermediary between the patient and the government. Thus a very large percentage of payments made to hospitals should continue to come from or through Blue Cross. If the traditional economic and contractual relationship between Blue Cross and the hospitals continues unchanged, the present inflationary trend in expenditures for hospital care can be expected to continue. In that event, the threat to the financial well-being of persons which now comes in the form of unaffordable medical bills would instead under NHI come in the form of unaffordable health insurance premium rates.

#### D. *State Statutes and Rules Governing Blue Cross*

Forty-eight states have enabling legislation for nonprofit hospital service organizations (*i.e.*, Blue Cross).<sup>84</sup> These enabling laws most often place the authority to regulate Blue Cross in the state's department of insurance—in forty-one states the insurance department has the responsibility for supervising Blue Cross, in two other states Blue Cross is regulated by some other state agency, while in a few states no regulatory agency is responsible for supervision of Blue Cross.<sup>85</sup>

The enabling legislation generally exempts Blue Cross from the provisions of state law applicable to commercial insurers, though certain sections of the law governing commercial insurers may be specifically included.<sup>86</sup> Areas where Blue Cross is subject to the same

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<sup>80</sup> RESOURCE BOOK, *supra* note 2, at 74-75.

<sup>81</sup> *Id.*

<sup>82</sup> *Hearings on NHI Before the House Comm. on Ways and Means*, 93rd Cong., 2d Sess., vol. 3, at 1031-68 (1974) (testimony of Walter J. McNerney, President, Blue Cross Association).

<sup>83</sup> RESOURCE BOOK, *supra* note 2, at 72-73.

<sup>84</sup> MARKUS & HAUCH, *STATE REGULATION OF PRIVATE HEALTH INSURANCE*, 80-83 (1972); S. LAW, *supra* note 1, at Ch. I (Introduction).

<sup>85</sup> S. LAW, *supra* note 1, at Ch. II, Sec. A.

<sup>86</sup> MARKUS & HAUCH, *supra* note 84, at 80.



requirements as commercial insurers commonly include limitations on investments an insurer may make, examination and reporting requirements, and policy form filing and approval procedures.<sup>87</sup>

In addition, the enabling laws often require an insurance department to review the composition of a Blue Cross plan's board of directors, limit a plan's subscriber contract forms, approve in advance all increases in subscriber rates, monitor existing rate levels, and review and monitor reimbursement contracts between a plan and its member hospitals.<sup>88</sup> Most state enabling laws do not, however, provide for a public hearing on proposed rate changes.<sup>89</sup> The standards set forth in the enabling laws for judging subscriber rates are generally quite broad. Terms such as "fair and reasonable" or not "excessive, inadequate, or unfairly discriminatory" are common.<sup>90</sup>

The enabling statutes in over ten states explicitly require the insurance commissioner to review the reimbursement contracts between Blue Cross plans and their member hospitals.<sup>91</sup> Although statutes in other states are silent on regulation of hospital reimbursement arrangements, regulation of subscriber rates in those states would necessarily appear to require examination of Blue Cross reimbursement to hospitals.<sup>92</sup> It is often impossible to make an intelligent analysis of the necessity of a rate increase without first examining the contractual relationships between the rate-charging regulatee and those suppliers from which it acquires the components of its product.

States have been quite sparing in their use of administrative rule-making powers to supplement powers provided by the enabling laws. Among all the states' regulatory agencies with authority over Blue Cross, apparently only the Ohio Department of Insurance has chosen to use its statutory administrative procedure act powers to promulgate formal regulations supplementing its statutory powers to regulate Blue Cross.<sup>93</sup> However, New Hampshire, Pennsylvania, Michigan, and West Virginia have used rule-making by adjudication (discussed *infra*) to adopt rules governing Blue Shield and Blue Cross.<sup>94</sup>

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<sup>87</sup> *Id.* at 83.

<sup>88</sup> *Id.* at 85.

<sup>89</sup> *Id.* at 102.

<sup>90</sup> *Id.* at 98, 99; S. LAW, *supra* note 1, at Ch. II.

<sup>91</sup> Idaho, Illinois, Iowa, Maryland, Massachusetts, Michigan, New Jersey, New York, South Dakota, Texas, MARKUS & HAUCH, *supra* note 84, at 104. Subsequent to Markus and Hauch's study, Ohio's law was amended to provide for examination of reimbursement contracts. OHIO REV. CODE § 1739.051 (1971).

<sup>92</sup> S. LAW, *supra* note 1, at Ch. II, Sec. A.

<sup>93</sup> *Ohio Rules Hearings*, *supra* note 23 (testimony of Sylvia Law and Sidney Wolfe, M.D.).

<sup>94</sup> *New Hampshire-Vermont Physician Service v. Durkin*, \_\_\_ N.H. \_\_\_, 313 A.2d 416 (N.H. 1973); *Opinion and Order of the Honorable Daniel I. Demlow, Commissioner of Insur-*

Indeed, before turning to administrative procedure act rule-making, Ohio unsuccessfully attempted to use rule-making by adjudication to promulgate rules governing Blue Cross.<sup>95</sup>

The regulatory mechanism established by these statutes is far from comprehensive. However, the present statutes do permit more effective regulation of Blue Cross than is attempted by the majority of state regulatory agencies. As Dr. Starkweather observed in 1970:

[A] number of states have granted powers to insurance commissioners which have not been fully exercised. Without either new regulation or new court precedent, government has the opportunity to exercise greater regulation if it so desires.<sup>96</sup>

The truth of this observation is borne out by the fact that the insurance departments of Pennsylvania, Ohio, New Hampshire, Michigan, and West Virginia have used statutes little or no different from those in force in most states to push Blue Cross in the area of cost control. When necessary, those state insurance departments have created needed new regulations either by use of their quasi-legislative rule-making powers or by use of their power to adjudicate rate cases.

But judging from their recorded efforts to date, states interested in actively regulating their nonprofit health insurance industry remain a small minority, so small that Professor Law introduces her book on Blue Cross by saying:

A major, and perhaps the most disturbing, theme of this book is the massive failure of the public regulatory agencies to regulate either Blue Cross or the hospitals in the interest of consumers.<sup>97</sup>

If states decide to become more active in their regulatory efforts, the experience of those states now engaged in regulation of Blue Cross can be instructive. The second part of this article will survey the regulatory programs of various states, concentrating on and analyzing the goals of those programs and the strategies being used to reach those goals.

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ance, *In re 1974 Rate Review of Michigan Hospital Service* (April 29, 1974) (on file at Michigan Department of Commerce, Insurance Bureau); Order of Samuel H. Weese, Insurance Commissioner, *In the Matter of Review of Certain Operations, Practices and Procedures of Blue Cross Hospital Service, Inc.*, Rate Filing of April 4, 1972 (Nov. 15, 1972), *rev'd* as to rate denied subscriber nominee. Rate filing of Blue Cross Hospital Services, Inc., Civil Action Nos. 11,956 and 12,054 (Cir.Ct.W.Va., June 13, 1973), reversal under appeal (all documents on file with West Virginia Insurance Commissioner).

<sup>95</sup> *In re Application of Blue Cross*, 34 Ohio Misc. 29, 33-36, 296 N.E.2d 305, 307-09 (Franklin Co. C.P. 1972).

<sup>96</sup> Starkweather, *Regulation of Health Insurance: A Review; Part II*, 1970 MEDICAL CARE REV. 474, 486.

<sup>97</sup> S. LAW, *supra* note 1, at 2.

## II. PROPOSED SOLUTIONS: REGULATORY STRATEGIES AVAILABLE TO STATES

### A. *Goals in Regulating Blue Cross*

The first part of this article demonstrated the misallocation problems caused by present methods of financing hospital care. In attempting to correct these problems, states are offering the following general goals:

1. Building incentives into the health care delivery system.

Of primary concern is a change in the retrospectively applied cost-reimbursement formula contained in the contract between Blue Cross and its member hospitals. To provide an incentive toward efficiency, the contract should contain a prospective cost-reimbursement formula whereby hospitals budget the whole year in advance and insurance companies set aside a certain amount based on that formula. The experience of health maintenance organizations is instructive in showing how incentives lead to cost efficiencies. The HMO's shift part of the risk associated with illness to providers, encouraging the latter to perform efficiently.<sup>98</sup> The regulators should require changes in Blue Cross plans whereby ambulatory care rather than hospital care is encouraged, as is the case with HMO's.

2. Encouraging community-wide planning in all areas of health care delivery.

This article has demonstrated that capital expenditures on hospitals are grossly inefficient. The regulator should require that Blue Cross (a) reimburse only those hospitals that participate in a program of genuine community-wide health care planning, and then (b) reimburse only for those capital and other expenditures deemed necessary for the health needs of the general community.

3. Encouraging the development of alternative forms of care.

Statistics cited earlier indicate that much of the cost crisis in the delivery of hospital care is caused by unnecessary hospital admissions and/or excessive number of days spent in hospitals. Under these circumstances, the states should consider ways to encourage the development of health care methods that do not involve admission to a hospital. At the same time, states should consider ways to identify and control, through peer review or otherwise, excessive lengths of stay, perhaps by shifting the cost of such stays to the attending physician or to the insurer.

4. Proscribing conflicts of interest.

The providers of health care face a conflict of interest when they

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<sup>98</sup> *Role of Prepaid*, *supra* note 27, at 997.

make policy decisions for Blue Cross that directly affect them financially. This conflict of interest in policy-making should be eliminated, although it may be prudent to retain providers in advisory capacities to Blue Cross.

5. Changing bargaining procedures.

In the private sector only the health insurers, in particular Blue Cross, have the economic muscle to bargain with the hospitals to obtain health care efficiencies. Clearly no hospital patient or group of patients has such economic power.

Adequate representation of subscribers is the standard the regulators should require of the health insurance industry. Even with the objective of reducing hospital costs the regulators should not demand that insurers produce specified results, for insurers may fail to eliminate unnecessary and inefficient costs in hospital operation although exerting a good faith effort. What the regulators should demand is a good faith effort by the insurers to use their economic muscle to fight rising health care costs.

The example of labor relations is instructive on this point. Under national labor law good faith bargaining involves going to the table together and making good faith proposals. The regulator can judge good faith by a look at "the whole record," "[t]he impact of all such occasions or actions, considered as a whole, and the inferences fairly drawn therefrom collectively. . . ."<sup>99</sup> The insurance regulator, by analogy, can determine whether the insurer is meeting its implied obligations to its subscribers by a look at its total activity. In addition, the regulator might require the insurer to bargain with the hospitals one by one, for that would enhance the bargaining position of the insurers.

In general, the goal of a state's regulatory efforts should be to move the health insurance industry (especially Blue Cross) from being a passive observer of the rise of health care costs to becoming an active intervenor on behalf of subscribers.

*B. Procedures Available for Reaching Those Goals*

An analysis of the enabling laws of most states reveals that, like most rate-making agencies, insurance departments generally have only two sanctions available to them for changing the behavior of Blue Cross: license revocation (or review of the certificate of incorporation, which is analagous) and rate-making.<sup>100</sup> Likewise, there are

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<sup>99</sup> *NLRB v. National Shoes, Inc.*, 208 F.2d 688, 692 (2d Cir. 1953).

<sup>100</sup> Note that while other economic sanctions such as fines or forfeitures are also available

two general methods available to insurance departments by which they can establish the norms toward which they want the behavior of Blue Cross to change: statutory reform and either quasi-legislative or quasi-judicial rule-making.

The rationale of each method of establishing norms and of each method of enforcing compliance should be examined.

### 1. Rule-making: quasi-legislative and quasi-judicial

Quasi-legislative rule-making, whereby rules prospective in nature and general in application are developed in the framework of a hearing convened solely for that purpose, is much like the procedure used by legislatures to develop and adopt new laws. Draft rules are proposed and distributed in advance of a hearing, a hearing is convened for the gathering of views about the rules, the rules are re-drafted to take into account the views expressed, and ultimately the rules are promulgated. The advantages of quasi-legislative rule-making or of statutory reform lie in the precision of the standards set up and in the certainty of agency outlook caused by that precision. Quasi-legislative rule-making does not in itself guarantee that any broader spectrum of viewpoints will be brought to bear on a problem, for rule-making hearings seem often to be dominated by industry viewpoint. Furthermore, when the rules deal with very new or complex problems, such hearings may bring forward no solutions at all.

Rules can also be developed on a case-by-case basis in adjudicatory proceedings. This procedure—variously called *ad hoc* rule-making or rule-making by adjudication—is the same procedure used any time one applies a general statutory standard to a specific set of facts and determines whether there is present or absent in the facts “fairness,” “lawfulness,” or the like.<sup>101</sup> Each impartial application of the standard to each new set of facts creates a new and narrower definition of “fairness” or “lawfulness” and creates a new “rule” governing conduct if that set of facts recurs. Even if this new “rule” is limited to precisely the facts being judged under the general standard, those who know that they may find themselves in the same factual circumstances in the future are bound to pay careful attention to these adjudication-made rules and to govern their behavior accordingly.<sup>102</sup>

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to enforce compliance with rules, periodic imposition of meaningful economic sanctions would differ little from periodic review and adjustment of rates.

<sup>101</sup> Some of these ideas are set forth in an earlier case comment by one of the authors of this article. See D. Brown, *Rule-Making by Adjudication in Rate-Making Proceedings—Some Notes on the Regulation of Blue Cross*, 604 INS.L.J. 264 (1973).

<sup>102</sup> Administrative agencies may exercise their discretion in the choice of formal rule-

## 2. Developing rules by adjudicating rate cases

In the 1968 *Permian Basin Area Rate Cases*,<sup>103</sup> the Supreme Court overruled the United States Court of Appeals for the Tenth Circuit and allowed to stand a Federal Power Commission decision in a classic case of rule promulgation in a rate-making adjudication.

The FPC chose an entirely new rate structure for natural gas pipeline companies in the Permian Basin, and in so doing formulated a pricing rule to promote the exploration and development of new sources of gas while keeping in force old prices for previously exploited gas. Under this new pricing rule, the FPC took into consideration matters other than the contract price paid by the pipeline companies for the gas they purchased. One of these additional factors was the public's interest in receiving gas at a fair price. Though this pricing method was entirely new, the FPC applied it retroactively to the case it was adjudicating.

The Supreme Court, per Mr. Justice Harlan, affirmed the FPC order *in toto*, with only Mr. Justice Douglas dissenting. The Court said:

The Commission may . . . employ price functionally in order to achieve relevant regulatory purposes. . . .<sup>104</sup>

In the *Permian Basin* rate proceedings, according to the Supreme Court, the FPC was faced with the following problem: "[D]eficiencies of the market mechanism . . . inability or unwillingness of interstate pipelines to bargain vigorously for reduced prices . . . [leading to] circumstances in which price increases unconnected with changes in cost may readily be obtained."<sup>105</sup> The market, according to the Court and according to the commission, was "essentially [a] monopsonistic environment,"<sup>106</sup> so that:

[c]onsumers [had] been left without effective protection against steadily rising prices. . . . The consumer [was] thus obliged to rely upon the Commission to provide "a complete, permanent, and effective bond of protection from excessive rates and charges."<sup>107</sup>

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making or rule-making by adjudication. The only limitation is that the agency must act consistently with the method it has chosen (*i.e.* it cannot promulgate formal rules through an adjudicatory hearing). See *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 290-95 (1974); *see, e.g., NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969) (plurality opinion per Fortas, J.).

<sup>103</sup> 390 U.S. 747 (1968).

<sup>104</sup> *Id.* at 797.

<sup>105</sup> *Id.* at 793-94.

<sup>106</sup> *Id.* at 794.

<sup>107</sup> *Id.* at 794-95.

The Supreme Court found that, given the changing market conditions, the FPC was fully justified in the procedure it used.<sup>108</sup>

In *Permian Basin*, the Supreme Court spoke clearly of the FPC's duty to use its rate-making power to protect the public interest, broadly defined:

[The Commission is] obliged at each step of its regulatory process to assess the requirements of the broad public interests entrusted to its protection by Congress. Accordingly, the "end result" of the Commission's orders must be measured as much by the success with which they protect these interests as by the effectiveness with which they "maintain . . . credit and . . . attract capital. . . ." The Commission's responsibilities necessarily oblige it to give continuing attention to values that may be reflected only imperfectly by producers' costs; a regulatory method that excluded as immaterial all but current or projected costs could not properly serve the consumer interests placed under the Commission's protection.<sup>109</sup>

The Supreme Court further pointed out that cost and noncost factors do not "race one against the other"; rather, they must be "harnessed side by side."<sup>110</sup>

This particular holding in *Permian Basin* has been closely followed in subsequent federal litigation.<sup>111</sup> In *Southern Louisiana Area Rate Cases*<sup>112</sup> the Fifth Circuit said:

We do not understand the law of industry regulation . . . to prohibit noncost elements that are based upon appropriate grounds. In *Permian* the Supreme Court unequivocally stated that the FPC is not bound by the sum of cost and return even if it adopts cost as the primary basis of its calculations.<sup>113</sup>

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<sup>108</sup> Ramifications of the FPC policy approved in *Permian Basin* have been criticized. See Dakin, *Ratemaking as Rulemaking—The New Approach at the FPC: Ad Hoc Rulemaking in the Ratemaking Process*, 1973 DUKE L.J. 41. However, this criticism of FPC policy is not relevant for the purposes of this article. Here the relevance of *Permian Basin* relates mainly to the procedure the Supreme Court upheld. The policy ramifications are significant only so far as they bear upon whether the procedure in any way caused a possibly unwise result. Here, it did not. *Contra, id.* The major procedural criticism one can aim at *Permian Basin* is that by the time the policy was put into effect times had changed drastically: an energy crisis was looming. (The proceedings began in 1960; the Supreme Court decided *Permian Basin* in 1968.) One can argue that the process took far too long, but the fault does not lie in the use of rule-promulgating adjudications. Federal agencies have become notorious for the time it takes them to make a decision, no matter what procedure is used.

<sup>109</sup> *Permian Basin Area Rate Cases*, 390 U.S. 747, 791, 815 (1968) (footnote omitted).

<sup>110</sup> *Id.* at 815.

<sup>111</sup> See, e.g., *Southern Louisiana Area Rate Cases*, 428 F.2d 407 (5th Cir. 1970), cert. denied, 400 U.S. 950 (1970) [hereinafter cited as *Southern Louisiana*]; *In re Hugoton-Anadarko Area Rate Case*, 466 F.2d 974 (9th Cir. 1972).

<sup>112</sup> *Southern Louisiana*, supra note 111.

<sup>113</sup> *Id.* at 426.

*Southern Louisiana* also adds support to the proposition that a regulator can look behind the application of the regulatee and examine contracts entered into and practices of the regulatee. In *Southern Louisiana* the court held that the regulator has the power to assess the consequences of a rate decision upon the industry, including "most importantly, the industry's probable conduct and performance as a result of the order."<sup>114</sup>

In following *Permian Basin* the Court of Appeals for the District of Columbia Circuit recently stated in *Mobil Oil Corp. v. FPC*:<sup>115</sup>

More significantly, the FPC's jurisdiction over rates chargeable by a producer includes authority to determine the reasonableness of costs incurred, *even though these are not subject to direct FPC control*, and that establishes authority to review royalty payments, or drilling rig rentals, *or any other element of the producer's cost of service*. [*Permian Basin Area Rate Cases*].<sup>116</sup>

This language from *Mobil Oil*, which cites *Permian* for its authority, illustrates the scope of inquiry which can be undertaken by a regulator which has been given the duty of deciding the rates at which a regulatee may sell its product to the public. The regulator implicitly has the authority to look at the fairness or reasonableness, not only of the price at which the product is sold to the public, but also of the terms under which the regulatee has acquired the components of the product. The relevance of such authority to the health insurance regulator is clear. From their inception Blue Cross associations have built into their operations heavy involvement of both hospital administrators and physicians. Thus health care providers are expected to represent health care consumers whose interests do not always coincide with those of the providers. Such a conflict of interest automatically calls for close scrutiny of contracts between the regulatee, Blue Cross, and the hospitals from which the regulatee purchases services.

A number of analogous state court cases lend support to broad-based determinations by rate-makers. In a recent case, *State ex rel. Utilities Commission v. General Telephone of the Southeast*,<sup>117</sup> the North Carolina supreme court affirmed a rate-making decision in which the North Carolina Utilities Commission promulgated rules applicable to the regulatee and to future regulatees. Faced with a case in which there was a close affiliation between the utility and a supplier of products for that utility, the court held that the effect of the affilia-

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<sup>114</sup> *Id.* at 441.

<sup>115</sup> 463 F.2d 256 (D.C. Cir. 1972).

<sup>116</sup> *Id.* at 263 (emphasis added).

<sup>117</sup> 281 N.C. 318, 189 S.E.2d 705 (1972).



tion is such that the "relationship calls for a close scrutiny by the Commission of the price paid by the utility."<sup>118</sup> "[T]he bargaining is not at arm's length and when the transaction is called in question, the burden is upon the utility to show that the price it paid was reasonable."<sup>119</sup> Similarly, the affiliation between Blue Cross and members hospitals should call for "close scrutiny" by regulators.

The court went on to hold that plant construction by the utility which the Utilities Commission deemed not in the best interests of the company and the public was not includible in the rate base. The court referred to some construction of buildings as padding the rate base, and added:

a utility may not inflate its rate base by extravagance in purchasing equipment or constructing its plant. In this connection, it is immaterial whether such extravagance be due to careless improvidence or to willful payment of exorbitant prices to an affiliate.<sup>120</sup>

Faced with a similar issue of whether certain construction and equipment for future use which would not benefit the present rate payers could be included in the rate base, the court held, "The present rate payers may not be required to pay excessive rates for service to provide a return on property which will not be needed in providing utility service within the reasonable future."<sup>121</sup> The remoteness of the benefits of some items included in the "reasonable cost" of hospital care<sup>121.1</sup> should also be considered by health insurance regulators.

Three Ohio supreme court decisions firmly establish that in Ohio an agency need not confine its inquiry to mere verification of the costs paid by a regulatee in producing its product but may properly inquire into whether the costs paid were reasonable.<sup>122</sup> The regulator is given express permission to look behind the contract to determine its fairness, and if it determines that the contract price is not fair, to lower the rate base accordingly.<sup>123</sup>

In *Ohio Mining Co. v. Public Utilities Commission*<sup>124</sup> the regulator was charged with seeing that utility rates were "just and reasonable" and "lawful." Two regulated electric companies that formerly

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<sup>118</sup> *Id.* at 345, 189 S.E.2d at 723.

<sup>119</sup> *Id.* at 346, 189 S.E.2d at 723.

<sup>120</sup> *Id.* at 344, 189 S.E.2d at 722.

<sup>121</sup> *Id.* at 353, 189 S.E.2d at 727.

<sup>121.1</sup> See note 41 *supra* and accompanying text.

<sup>122</sup> *Ohio Mining Co. v. Public Utilities Comm'n*, 106 Ohio St. 138, 140 N.E. 143 (1922); *Southern Ohio Power Co. v. Public Utilities Comm'n*, 110 Ohio St. 246, 143 N.E. 700 (1924); *East Ohio Gas Co. v. Public Utilities Comm'n*, 133 Ohio St. 212, 12 N.E.2d 765 (1938).

<sup>123</sup> *Id.*

<sup>124</sup> Cited *supra* note 122.

purchased power to sell to subscribers from independent generating companies began purchasing power at higher cost from a generating company that was now a sister subsidiary of their common parent. The Ohio supreme court ordered the Public Utilities Commission to lower the rates collected by the electric companies. The court specifically found that the commission could use its rate-making power over the regulated producer to examine the regulatee's relationship with its suppliers and to force the regulatee to change the terms of its contract with its suppliers<sup>125</sup> when that contract contravened the public interest in obtaining electric power at fair rates. The standard implicitly adhered to by the Ohio supreme court was that a producer and its suppliers must bargain "at arm's length."

It appears that public utilities commissions have plenary authority to scrutinize closely the relationship between regulatee and supplier of a product to the regulatee. Regulators of Blue Cross probably have similar authority. Both public utilities and Blue Cross associations are community-wide services. Blue Cross was created as an instrument for making health care available to the entire community; public utilities were created to provide their services to a similarly broad segment of the community. Thus the analogy between regulation of public utilities and regulation of health insurance associations is apposite.

The New York case of *Thaler v. Stern*<sup>126</sup> makes the analogy explicit. That case dealt squarely with the issue of what factors a superintendent of insurance must appraise when considering a rate increase. The court was asked to review action taken by a superintendent of insurance on a rate application by a hospital service corporation called AHS (a Blue Cross-type organization). The superintendent's approval of a rate increase was being challenged because he had refused to consider (1) AHS's failure to exert influence over hospital costs and inefficiencies, (2) the effect that this failure had on the rate of reimbursement of the hospitals by AHS, and (3) the effect of all the foregoing on subscriber rates. Although the court affirmed the decision as being within the superintendent's discretion, it stated that the superintendent had a duty to consider the effect of hospital costs and inefficiencies on the reimbursement rate and thus on subscriber rates:

In 1960, respondent's predecessor when approving the basic formula, recognized that "the reasonableness of any hospital reimbursement proposal must necessarily be assessed in light of—though

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<sup>125</sup> *Ohio Mining Co. v. Public Utilities Comm'n*, *supra* note 122, at 142, 140 N.E. at 144.

<sup>126</sup> 44 Misc. 2d 278, 253 N.Y.S.2d 622 (Sup.Ct. 1964).

not controlled by—the structure of current hospital pricing procedures.” An evident corollary of this is that the reasonableness of any subscriber rate proposal must necessarily be assessed in the light of the operation and effect of the hospital reimbursement formula. We reject the restrictive interpretation the Superintendent puts upon his authority. Surely, we must conclude, by implication if not otherwise, that the Superintendent has been empowered to do all that is reasonably necessary to fulfill the duties imposed upon him [*i.e.*, to determine if a proposed rate increase is either inadequate or excessive].<sup>127</sup>

The court went on to say that, in order to protect the subscribers, the superintendent should actively intervene in the contractual arrangements between the regulatee (the Blue Cross association) and the hospitals when the public interest requires it.

In summary, *Ohio Mining Co. v. Public Utilities Commission*<sup>128</sup> and *State ex rel. Utilities Commission v. General Telephone of the Southeast*<sup>129</sup> stand for the proposition that a rate-making agency does not have to grant a rate increase simply because the costs paid by the rate-charging regulatee have risen. The state supreme courts deciding those cases obviously believed that in rate matters what lies behind the cost figures is as important as the cost figures themselves. Management and policy decisions made by regulatees in the course of running their businesses may account for most of the costs reflected in the rate increase application. To ignore what lies behind the application would be to allow regulatees to build an equitable claim to a rate increase in circumstances where the need was of their own making and would disappear if management and policy decisions were changed.

*Thaler* refined the concept the above cases put forward. According to that decision, the regulator should intervene to stop contracts which the regulatee plans to enter into if they significantly injure the public. The honorable intent of the regulatee or the absence of any harmful overt act is irrelevant. Hence, the failure to bargain effectively for a new contract is in itself a reason to deny the rate sought to be charged to the consumer.

*Permian Basin* seems to carry those regulatory considerations to their fullest development. In *Permian Basin* the Supreme Court said that in making rules during the adjudication of a rate increase request a regulator is not limited to proscribing those costs incurred because

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<sup>127</sup> *Id.* at 288-89, 253 N.Y.S.2d at 633.

<sup>128</sup> Cited *supra* note 122.

<sup>129</sup> Cited *supra* note 117.

there is chicanery in economic bargaining due to some allied relationship,<sup>130</sup> or even to proscribing business activities that are inconsistent with normal business practices.<sup>131</sup> *Permian Basin* gives the regulator authority to change the behavior of the regulatee even when the latter is acting ethically and following normal business practices. In effect, the regulator is given the authority to change the regulatee's behavior from one honest and fair business practice to another honest and fair business practice.<sup>132</sup> Future regulatee behavior as a result of the rates set is thus a crucial factor in regulation.<sup>133</sup>

### 3. The advantages of rule-making by adjudication

The reasons that an agency oftentimes makes its rules in an adjudication are set forth in the landmark *Chenery II*<sup>134</sup> case:

Not every principle essential to the effective administration of a statute can or should be cast immediately into the mold of a general rule. . . . [P]roblems may arise in a case which the administrative agency could not reasonably foresee, problems which must be solved despite the absence of a relevant general rule. Or the agency may not have had sufficient experience with a particular problem to warrant rigidifying its tentative judgment into a hard and fast rule. Or the problem may be so specialized and varying in nature as to be impossible of capture within the boundaries of a general rule. . . . There is thus a very definite place for the case-by-case evolution of statutory standards.<sup>135</sup>

This approach indicates a twofold justification for rule promulgation by adjudication. First, the accumulation of experience in individual cases must precede any effort to elaborate statutory standards in a way that realistically deals with the myriad actual problems an agency must consider. Simply to choose general rule-making may result in overlooking some aspects of the problem or even in proposing the wrong solutions. Adjudication-made rules, however, can eventually be "codified" into formal rules after the full benefit of regulatory experience is obtained.<sup>136</sup>

Second, the legislature may order an agency to find what is "fair" or "just" or "reasonable" or "in good faith,"—legislative

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<sup>130</sup> See text accompanying note 122.

<sup>131</sup> See text accompanying note 117.

<sup>132</sup> See text accompanying note 113.

<sup>133</sup> See text accompanying note 114.

<sup>134</sup> *SEC v. Chenery Corp.*, 332 U.S. 194 (1947) [commonly known as *Chenery II*].

<sup>135</sup> *Id.* at 202-03.

<sup>136</sup> See Shapiro, *The Choice of Rule-Making or Adjudication in the Development of Administrative Policy*, 78 HARV. L. REV. 921, 927 (1965).

catch-alls that are often the backbone of an administrative statute. With such a mandate, it may never be desirable for an agency to make rules via a formal hearing and adhere to them, for the determination of these criteria is a continually evolving process as the demands of the society change. The second justification, therefore, is that the agency must continue to evolve standards and set policies gradually in order to follow the rather general legislative command. Rule-making by adjudication is the best approach when the standard that the statute sets up is, in Justice Cardozo's words, "a way of life."<sup>137</sup> The continuing vitality of rule-making by adjudication is shown by its unanimous acceptance in *NLRB v. Bell Aerospace Co.*<sup>138</sup>

Rule-making by adjudication is particularly useful for the application of a new statute. Given the legislative intent in creating administrative agencies, it is good policy and good law to allow more flexibility, both substantive and procedural, to an administrative agency when it formulates a *res nova* application of a recently-enacted statute than when it is involved in an ensuing application of that statute.

Among the purposes of adjudication is to evolve standards, to experiment with tentative policy solutions. An agency may not have had sufficient experience with a problem to develop a hard-and-fast rule, so it proceeds as a court might under common law. By such an approach the needed rule is found and not made; human experience may often be the best background an agency can acquire as it moves toward a formal rule.<sup>139</sup> Such an approach follows the Holmesian adage: "The life of the law is not logic; it is experience."

The reasons for the need to promulgate rules in a *res nova* proceeding in an adjudicatory framework can be garnered from Professor Shapiro's article:

[T]he accumulation of experience in individual cases is a necessary prelude to any effort to elaborate statutory standards in a manner that deals realistically with actual problems rather than with hypothetical cases that may never arise. In still others, specific rules may subtract from the force of a general statutory prohibition by inadvertently setting up guideposts for evasion of the basic statutory objectives.

In addition, there are numerous situations in which the only course that is consistent with the legislative purpose is to apply the statute to the facts without attempting to articulate more precise

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<sup>137</sup> *Welch v. Helvering*, 290 U.S. 111, 115 (1933).

<sup>138</sup> *Supra* note 102.

<sup>139</sup> Shapiro, *supra* note 136.

rules governing the applicability of the standard. . . . Moreover, the very absence of a specific grant of authority to issue regulations on a given subject may be a significant factor in leading a court to conclude that the administrator cannot commit himself in advance by drawing hard-and-fast lines but must exercise his discretion in each case.<sup>140</sup>

The Supreme Court has recognized the need to use rule-making by adjudication in a *res nova* proceeding. In *Atlantic Refining Co. v. Public Service Commission of New York* (the CATCO case),<sup>141</sup> the Court indicated that the administrator needs more flexibility and should be given wider discretion during the "formative period when the ground rules of producer regulation are being evolved."<sup>142</sup> *Chenery II* also recognized the distinction between a *res nova* proceeding and a change in settled law, and the need for an administrator to have more discretion to experiment in the former context.<sup>143</sup>

The Supreme Court has recognized for at least a quarter of a century that the standard of review where a new principle is announced and applied can be no stricter than the standard of review in an ordinary administrative action.<sup>144</sup> In recent years the Court has stated that it is less willing to overrule an agency decision in an experimental stage of regulation, realizing that improvements will come as regulation in the new area becomes better understood by the agency.<sup>145</sup>

*Southern Louisiana*<sup>146</sup> is an especially good example of the application of the principle by a United States Court of Appeals. For here the court was clearly dissatisfied with both the procedure used and the result reached by an agency. But the agency was sustained in view of the experimental stage of area regulation.<sup>147</sup> The court promulgated guidelines for the agency to follow in future proceedings, believing that definite improvements would come as the agency became more proficient in applying the particular statutes and regulations.

#### 4. Superiority of rate-making over licensing

It was noted above that a rate-making agency's statutory author-

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<sup>140</sup> *Id.* at 927-28 (footnote omitted).

<sup>141</sup> 360 U.S. 378 (1959).

<sup>142</sup> *Id.* at 391.

<sup>143</sup> *Chenery II*, *supra* note 134, at 207.

<sup>144</sup> *Permian Basin*, *supra* note 103, at 788.

<sup>145</sup> *Id.* at 772, 816. This principle was followed in *Southern Louisiana*, *supra* note 111, and in *Amalgamated Meat Cutters and Butcher Workmen v. Connally*, 337 F. Supp. 737 (D.D.C. 1971).

<sup>146</sup> Cited *supra* note 111.

<sup>147</sup> *Id.*

ity is often limited to two types of adjudications, licensing and rate-making. As has been pointed out, until recently the rate-making power has rarely been used to regulate behavior, and even now it is used sparingly. This section demonstrates that rate-making is superior to licensing as a regulatory tool.<sup>148</sup> There are a number of reasons why the rate-making power is a more useful and more refined tool of regulation than the licensing power.

First, the rate-making power motivates positively, whereas the licensing power motivates negatively. Second, the rate-making power has creative force; the licensing power has only destructive force. Third, the rate-making power can be used gradually and in degree; the licensing power has a summary quality that precipitates rapid confrontations and quick showdowns.

When the regulator uses its rate approval power the regulatee has something positive to gain if it changes its behavior, for it can meet the regulator's standard and then return and obtain a rate increase. Under the licensing power the regulatee is primarily motivated by the fear of extinction. Actions of regulatees in response to fear, while quicker, are less likely to be creative and innovative than actions in response to promise of reward. In fact, the threat of extinction might cause the regulatee to change in too abrupt and too final a way. The possibility of creative and gradual change is lost with use of the licensing power. The ultimate threat contained in that power—seizure—places so much force behind regulator decisions that regulatees may frequently react to them badly.

In fact, the power to revoke licenses is of such magnitude that it is often not a useful tool at all for molding and shaping the conduct of regulatees. Regulatees of any substantial economic worth or social importance realize that the chances of a license revocation are inversely related to their size or worth. Few regulators or judges would permit a large company to be seized and/or liquidated because of its policies, unless those policies were extraordinarily inimical to the public interest. And if regulated entities do not fear license revocation, then an agency's threats do little to influence the way in which company affairs are run. The licensing power is simply too unrefined to pose a credible threat.

The inadequacy of this type of regulatory tool was recently expressed by the first Administrator of the Environmental Protection Agency, who had been given the astoundingly awesome authority to shut down the auto companies: "We had a 'nuclear deterrent': putting

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<sup>148</sup> Some of these ideas were set forth in an earlier case comment cited at note 101, *supra*.

them out of business. . . . Putting them out of business is no sanction at all."<sup>149</sup>

### C. *Present Efforts to Use These Methods*

#### 1. Statutory reform

A survey of present state laws governing Blue Cross reveals that in most states there has been little statutory change in recent years. While a few states, including Alabama<sup>150</sup> and Illinois,<sup>151</sup> have recently amended their laws to curtail provider domination of the boards of trustees of Blue Cross plans in their states, many statutes still require majority representation of providers on Blue Cross boards. The law of Georgia is typical in providing that

[a]t least a majority of the directors of such [Blue Cross] corporation must be at all times directors, superintendents, or trustees of hospitals, as herein defined, which have contracted or may contract with such [Blue Cross] corporation to render its subscribers hospital service.<sup>152</sup>

The number of states that empower the insurance regulator to examine the contractual relationship between Blue Cross and hospitals has recently increased,<sup>153</sup> but the increase has been slight. Similarly, few states have acted by statute to remove tax-exempt status from Blue Cross organizations which have taken on the characteristics of commercial insurers.<sup>154</sup>

To facilitate state adoption of more effective statutes governing Blue Cross, the Health Law Project of the University of Pennsylvania Law School has prepared a Model Consumer Blue Cross Statute,<sup>155</sup> which has received consideration from several state insurance departments. This model statute articulates the role of Blue Cross as agent and advocate of its subscribers and specifies a number of practices and procedures for Blue Cross to adopt to improve its performance in this role.

The model act provides, first, that a Blue Cross board of direc-

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<sup>149</sup> Remarks of William Ruckelshaus, Yale University School of Law, New Haven, Conn., Nov. 21, 1973.

<sup>150</sup> ALA. CODE tit. 28, § 306, *as amended*, (1973).

<sup>151</sup> ILL. REV. STAT. ch. 32, § 554, *as amended*, (1973).

<sup>152</sup> GA. CODE § 56-1709 (1971).

<sup>153</sup> OHIO REV. CODE § 1739.051, *as amended* (1971); FLA. STAT. § 641.03; ILL. REV. STAT. ch. 32, § 555, *as amended* (1973).

<sup>154</sup> See, e.g., ALA. CODE tit. 28, § 316, *as amended* (1969).

<sup>155</sup> Model Consumer Blue Cross Statute, drafted by Andreas Schneider, on file at Health Law Project, University of Pennsylvania Law School.



tors or trustees will be composed entirely of subscribers, who shall be elected by subscribers on an annual basis and who shall represent the demographic characteristics of the subscriber population as a whole. This subscriber board is empowered to obtain technical advice from a provider advisory panel. Second, the determination of whether a rate increase should be granted to Blue Cross is made to depend in large measure on whether Blue Cross has made a vigorous, good faith effort to control the rates it pays to hospitals. Third, no approval of a subscriber contract or an amendment thereto may be obtained without opportunity for comment by subscribers. In the same vein, the model statute provides that no rate increases can be granted without opportunity for public comment and a public hearing. Fourth, the act calls for careful scrutiny by the insurance department of reimbursement contracts between Blue Cross and hospitals, with particular attention to cost control devices contained in the contract. Fifth, an insurance department is given the clear right to be present at semi-annual negotiations between hospitals and Blue Cross on the subject of reimbursement rates, and a transcript of the negotiations must be kept.

These and other provisions of the Model Consumer Blue Cross Statute offer a number of courses of action designed to make Blue Cross more responsive to subscriber needs and to eliminate the inflationary tendencies of its present contractual relationship with member hospitals.

## 2. Quasi-legislative rule-making

The administrative procedure acts of at least some states give a state department of insurance the authority to make formal rules applicable to the nonprofit health insurance industry. As noted above,<sup>156</sup> apparently only the Ohio Department of Insurance has chosen to regulate Blue Cross through formal rules promulgated pursuant to the state's administrative procedure act. The Ohio rules,<sup>157</sup> like the Model Consumer Blue Cross Statute, focus on the relationship between Blue Cross plans and their member-hospitals. By mandating the inclusion of some terms in the reimbursement contract and by setting up guidelines governing the periodic renegotiation of that contract, these rules attempt to build into the contractual relationship between Blue Cross and the hospitals a strong scheme of cost control.

Under the Ohio rules, Blue Cross is prohibited from reimbursing

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<sup>156</sup> See note 93 *supra*.

<sup>157</sup> Rule IN-1739-01, drafted by Insurance Department staff members Michael Schonbrun and William Shkurti, effective Oct. 1, 1974 (on file with Ohio Department of Insurance).

member hospitals for construction of facilities or purchase of equipment not deemed necessary by regional planning authorities. Similarly, where existing services or facilities of Blue Cross member-hospitals are deemed duplicative or unnecessary by regional planning authorities, the rules require Blue Cross to bargain in good faith with member-hospitals toward consolidating or phasing out the redundant services or facilities.

The rules also require that the board of trustees and every committee of the plan have a two-thirds consumer majority, which should reflect the demographic characteristics of the plan's subscribers. Finally on this subject, the rules provide for exclusion of all of a plan's present trustees from selection of future trustees.

On the topic of financial management of a plan, the rules provide that Blue Cross must bargain in good faith with member-hospitals toward the latter's adoption of cost-conscious purchasing practices and use of presently available management information systems and industrial engineering services. The rules also set a two-month limit on a plan's contingency reserves and provide for the return to subscribers of excess reserves. To create an additional check on expenditures by hospitals, the rules provide, first, that after having been hospitalized such subscriber shall get a clear, comprehensive and specific bill from the hospital and, second, that the subscriber and the plan will be held harmless from medical expenses adjudged unnecessary by a recognized group which reviews utilization of hospital services. The rules also provide for disclosure of a hospital's salary or fee expenditures for ancillary specialists such as anesthesiologists, radiologists, and pathologists and of a hospital's expenditures related to promotional, lobbying, or public relations activities.

These Ohio rules, which became effective on October 1, 1974, set forth some of the regulatory possibilities available under the administrative rule-making powers given to state agencies by state administration procedure acts.

### 3. Rule-making by adjudication

Rule-making by adjudication has been used by a number of state departments of insurance including those of Pennsylvania, Ohio, West Virginia, New Hampshire, and Michigan. The New Hampshire supreme court affirmed that rule-making by adjudication is an acceptable means of regulation of the health insurance industry; in West Virginia a county court stated that such a procedure was unauthorized for agency use; in Ohio an appellate court has found the procedure unacceptable; and in Michigan and Pennsylvania the procedure has not yet been tested in the courts. In addition, in New York a court

in dictum admonished the state insurance department for not using rule-making by adjudication.

A 1958 Pennsylvania adjudication antedates similar efforts in other states by a dozen years. The insurance commissioner denied a rate increase to Philadelphia Blue Cross, at the same time issuing an order to Blue Cross containing eight directives on how it should discourage inefficiency and unnecessary costs in the operation of its member hospitals.<sup>158</sup> The directives included various types of vigilance over hospital practices and threatened disapproval of future reimbursement contracts with Blue Cross member hospitals that did not put into effect certain cost-saving practices. One commentator called the adjudication a "backdoor" type of regulation of hospitals.<sup>159</sup> The adjudication was apparently never appealed to the courts. The Commissioner's actions were an ideal example of rule promulgation in rate-making adjudications on topics only indirectly related to apparent fiscal need of the regulatee.

More recently, the Pennsylvania Commissioner of Insurance, Herbert Denenberg, chose a procedure somewhat between rule-making by adjudication and formal rule-making. Denenberg, the nation's best-known insurance regulator, issued a series of sixty-two guidelines proposed for inclusion in Blue Cross hospital contracts.<sup>160</sup> In so doing, Denenberg aided a rather unusual Blue Cross association, Blue Cross of Greater Philadelphia, which has engaged in no-holds-barred bargaining with its member-hospitals.<sup>161</sup>

In *Thaler v. Stern*,<sup>162</sup> a New York case, discussed at length above, the court in effect lectured the insurance department for not developing cost-control rules in its rate-making adjudications. However, since the court also found that the particular rate increase granted by the department was necessary to the continued solvency of Blue Cross, it affirmed the insurance department's order.

Before adopting formal rules applicable to all Blue Cross organizations in his state, the Ohio superintendent of insurance used rule-making by adjudication in hearings on rate increase applications of specific Blue Cross organizations. Between 1971 and 1973, the super-

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<sup>158</sup> *Adjudication of Francis R. Smith, Commissioner, In re Associated Hospital Service* (April 15, 1958). The adjudication is apparently unreported. It was discussed by several commentators; see, e.g., Simpson, *Non-Profit Hospital Service Plans*, 8 CLEV.-MAR. L.REV. 492, 499-500 (1959), and Starkweather, *Part I*, *supra* note 60, at 348-49.

<sup>159</sup> Starkweather, *Part I*, *supra* note 60, at 349.

<sup>160</sup> H. DENENBERG, GUIDELINES FOR INCLUSION IN BLUE CROSS CONTRACT WITH DELAWARE VALLEY HOSPITAL ASSOCIATION AND RESPONSE OF BLUE CROSS (1973).

<sup>161</sup> NHI REPORTS 9 (1973).

<sup>162</sup> 44 Misc. 2d 278, 253 N.Y.S.2d 622 (Sup. Ct. 1964).

intendent denied the rate increase applications of four Blue Cross organizations after lengthy hearings. Ohio law requires that a Blue Cross rate increase be "fair, lawful, and reasonable."<sup>163</sup> In each case the superintendent held that due to certain practices of Blue Cross the granting of a rate increase would be "other than fair, lawful, and reasonable." In particular, the rate increase was determined to be contrary to the statute because Blue Cross had allegedly "failed to exert any effective influence over its member hospitals to operate more efficiently."<sup>164</sup>

The Ohio superintendent of insurance's use of rule-making by adjudication thus far has not fared well in Ohio courts. All four adjudications were appealed by Blue Cross. One of the appeals is still pending. In the remaining three appeals the superintendent's use of rule-making by adjudication was struck down.

In one case, *In re Application of Blue Cross of Northwest Ohio* (1973),<sup>165</sup> the court of appeals affirmed the lower court which had upheld the superintendent's order on the grounds that the rate increase was "other than lawful, fair, and reasonable," but it stated in unequivocal language that the superintendent could not use rule-making by adjudication, adding that it did not believe *Chenery II*<sup>166</sup> to be good law in Ohio.<sup>167</sup>

The other two appeals from the superintendent's orders resulted in the orders being overturned, on the ground that the superintendent had no authority to promulgate retrospective rules in the adjudication.<sup>168</sup>

The use of rule-making by adjudication in Blue Cross rate-making hearings to control hospital costs is, at this point, also unacceptable in West Virginia. In a 1972 hearing, Commissioner Weese of the West Virginia department of insurance denied a rate increase to Blue Cross on the ground that Blue Cross did not attempt to control hospital costs on behalf of its subscribers.<sup>169</sup> The commissioner was authorized to approve rates which were "not excessive,

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<sup>163</sup> OHIO REV. CODE § 1739.051 (1971).

<sup>164</sup> See the following hearings on file with the Ohio Department of Insurance: *Blue Cross of Central Ohio*, *Blue Cross of Northwest Ohio*, *Blue Cross of Canton, Ohio* and *Blue Cross of Lima, Ohio*.

<sup>165</sup> 40 Ohio App. 2d 285 (Franklin Co. C.P. 1973).

<sup>166</sup> 332 U.S. 194 (1947).

<sup>167</sup> *In re Application of Blue Cross* (1973), *supra* note 165, at 291-92.

<sup>168</sup> *In re Application of Blue Cross*, 34 Ohio Misc. 29 (Franklin Co. C.P. 1972). *In re Blue Cross of Canton, Ohio*, Case No. 73CV-01-146 (C.P. 1973), *aff'd*, Ct. App. Franklin Co., Case No. 73-AP-497 (Aug. 27, 1974) (now under appeal to Ohio supreme court).

<sup>169</sup> *Proceedings Before Samuel H. Weese, Insurance Commissioner of West Virginia, Administrative Hearing 72-10*.

inadequate, or unfairly discriminatory.”<sup>170</sup> The commissioner found that there was a lack of “arm’s length negotiations” between Blue Cross and its member-hospitals, and that the “reimbursement contract . . . [was] unfavorable to Blue Cross subscribers.”<sup>171</sup> The commissioner determined that he had authority to inquire into the reasonableness of the reimbursement contract between Blue Cross and the hospitals and denied the rate increase because the reimbursement contract was deemed unreasonable.

On appeal, the commissioner’s order was overturned.<sup>172</sup> The court held that hospital rates and the reimbursement contract between Blue Cross and the hospitals could not be corrected via rule-making by adjudication, citing *In re Application of Blue Cross of Central Ohio* (1972).<sup>173</sup> The court noted there are “other means of correcting the [Blue Cross] abuses,”<sup>174</sup> although it did not indicate what those “other means” were.

The New Hampshire supreme court has unanimously stated that rule-making by adjudication may be utilized in rate-making hearings for a nonprofit health insurance company in order to improve health care services to subscribers.<sup>175</sup>

In 1972 Commissioner Durkin of the New Hampshire department of insurance ordered a rate-making hearing on the state’s Blue Shield organization. In May, 1973, the commissioner ordered a decrease in Blue Shield rates on the ground that its contingency reserve was too high. The commissioner ordered an upgrading of services to subscribers, including broader coverage and an elimination of distinctions in coverage and rates between group and nongroup subscribers and made several recommendations, including the merger of Blue Shield and Blue Cross and reconstituting of the membership of the board to reflect the demographic characteristics of the subscribers.<sup>176</sup>

The Supreme Court of New Hampshire held that the commissioner had the authority to do all that he did.<sup>177</sup> First, the court citing *Chenery II* as authority<sup>178</sup> upheld rule-making by adjudication in a

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<sup>170</sup> W.VA.CODE. § 33-24-6(c) (1972).

<sup>171</sup> *Supra* note 169, at 9-10.

<sup>172</sup> Rate Filing of Blue Cross Hospital Service, Inc., Civil Action No. 11,956 and Civil Action No. 12,054 (Cir.Ct.W.Va. 1973).

<sup>173</sup> *Supra* note 168.

<sup>174</sup> *Supra* note 172, at 9.

<sup>175</sup> *New Hampshire-Vermont Physician Service v. Durkin*, \_\_\_\_ N.H. \_\_\_\_, 313 A.2d 416 (per Kenison, C.J.) (1973).

<sup>176</sup> *Id.* at \_\_\_\_, 313 A.2d at 418.

<sup>177</sup> *Id.* at \_\_\_\_, 313 A.2d at 419-21.

<sup>178</sup> *Id.* at \_\_\_\_, 313 A.2d at 420.

rate-making hearing as a valid means to regulate Blue Shield.<sup>179</sup> The court then stated that the commissioner indirectly had the authority to regulate the service provided by the health insurance company:

[a] necessary concomitant to the commissioner's authority to find rates "inadequate or discriminatory" would be the ability to establish the minimum level of services offered by the corporations for the protection of subscribers.<sup>180</sup>

However, the court remanded the case to the commissioner because it found that the record could not reasonably support any of his findings.<sup>181</sup> The recommendations were not dealt with because they were not legally binding.<sup>182</sup>

In April 1974 Michigan Commissioner of Insurance Demlow made the following conclusions from a Blue Cross rate-making hearing: Blue Cross' use of a retrospective rather than a prospective reimbursement formula caused higher rates to subscribers; Blue Cross was failing to eliminate wasteful health care delivery practices such as overbedding; and Blue Cross was spending too much on advertising.<sup>183</sup> The commissioner therefore denied the rate increase and promulgated some rules. The rules provided that Blue Cross should use prospective reimbursement more frequently and that it should begin to eliminate wasteful health care delivery practices. Moreover, Blue Cross was to submit all advertisements to the insurance bureau for prior approval. Failure to comply with any of those orders would result in denial of future rate increases.<sup>184</sup>

### III. CONCLUSION

Responsibility for regulation of health insurance generally and of Blue Cross in particular has been committed to state insurance departments during the entire period of the health care crisis mentioned throughout this article. In states where the regulators have had the will, presently existing statutes have provided an adequate starting point for regulation. Unfortunately, as pointed out earlier, the overall record by state regulators indicates lethargy. Yet the recent activity by some state insurance departments suggests that a prediction made four years ago may soon be a reality:

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<sup>179</sup> *Id.*

<sup>180</sup> *Id.* at \_\_\_, 313 A.2d at 421.

<sup>181</sup> *Id.* at \_\_\_, 313 A.2d at 421-22.

<sup>182</sup> *Id.* at \_\_\_, 313 A.2d at 422.

<sup>183</sup> *In re 1974 Rate Review of Michigan Hospital Service*, Daniel Demlow, Insurance Commissioner, April 29, 1974, cited *supra* note 94.

<sup>184</sup> There has yet to be an appeal.

[T]here is the likelihood of expanded efforts on the part of insurance commissioners to control hospital and physician costs, using insurance regulations as the indirect mechanism. . . . Since insurance increases the demand for medical services, it is appropriate that public concern over increased use takes the form of insurance commissioner activity.<sup>185</sup>

With the rapid approach of national health insurance and the near certainty of the continued use of the nonprofit health insurance industry as an integral part of the operation of the nation's health care delivery system, it is to be hoped that the states use and expand their regulatory powers in a way that will prevent the defects in the present system from contaminating national health insurance.

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<sup>185</sup> Starkweather, *Part II, supra* note 96, at 487.

Though the major repository of power to regulate the nonprofit health insurance industry is the insurance departments of the several states, recent developments indicate some potential for direct citizen influence on the regulatory process. Private citizens have sometimes acted to bypass state insurance departments and, with varying degrees of success, have intervened in and/or appealed from rate adjudications by state insurance departments. *Thaler v. Stern, supra* note 126. In some places, antitrust actions have been filed. *Borland v. Bayonne Hospital, supra* note 53. In other areas, citizens are making use of openings on Blue Cross boards of trustees created by amendments in the statutes. *See, e.g.,* OHIO REV. CODE § 1739.04 (1972). Direct citizen action is potentially a viable alternative to state regulation, but there is currently very little activity in the area, and, consequently, very little law has developed.